COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

February 11, 2020
11:00 A.M.
Cabinet for Health and Family Services
Medicaid Commissioner's Conference Room
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

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CHAIR

Annlyn Purdon
Susan Stewart
TAC MEMBER PRESENT

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Holly Owens
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Cathy Stephens
Guy Custers
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AETNA BETTER HEALTH

Pat Russell
WELLCARE

AGENDA

1. Call to Order

2. Welcome and Introductions

3. Approval of Minutes

4. Old Business
   * Followup on MCO request for a full listing of supplies and billing quantities

5. New Business
   * What role the administration expects Home Health to play as it moves forward. What changes/ opportunities are on the horizon and what can the industry do to help gather information/data in order to facilitate those changes. If none have been contemplated, can we make suggestions about how to move forward?
   * As to the TAC itself, under the previous Commissioner, we had the impression that the TACs were intended to receive suggestions/ recommendations for new and different policies to be considered by DMS. The feedback from DMS at our last meeting suggested to us that there may have been a change in that direction and we would like to understand what the approach from DMS is so that we can be on the same page.

6. Adjournment

MS. HUGHES: If we could let the Commissioner go first on the agenda, that would help.

MS. DYER: We will introduce everyone real quick. Thank you for being here today.

(INTRODUCTIONS)

DR. DYER: Welcome, Commissioner Lee. We're glad you're here. Do you want to say anything since you've got limited time in here before we even get to the agenda items?

COMMISSIONER LEE: Just quickly for those of you who do not know me. I am returning to Medicaid. I previously worked in Medicaid for sixteen years in Kentucky.

I did a lot of different things when I worked in Medicaid. I usually tell everybody I was a Member Service Representative, I was a Provider Service Representative, a CHIP Director, a Policy Analyst and I eventually was a Deputy Commissioner and, then, I was Commissioner before I retired.

So, when I was asked to return to Medicaid, I thought about it just a little bit and, then, decided I think this is where I want to

be because the Medicaid Program is near and dear to my heart. I worked in it for sixteen years. I know a lot of the issues that the members face. I also know a lot of the issues that the providers face.

And I think that our role, everybody in this room is here for the same reason. We're here to improve the health status of Kentuckians and this is a partnership. We work together. Medicaid can only do so much. The providers are out in the field. They're the eyes and ears in the community to tell us what's going on. We have our MCO partners also.

And, so, I think together that we can move the state forward in a direction that improves the status of those that we are charged to serve and I think that that's our main mission is to see how well we're taking care of the lives that are enrolled in Medicaid and how we can improve those lives.

MS. DYER: Lots of years of experience.

COMMISSIONER LEE: Yes, a few, but even after sixteen years and, then, four years I worked with other state Medicaid agencies, you learn something new every single day in the Medicaid

Program, every day. It's a very vast and complex program.

DR. DYER: When it all settles, it's all about serving the patients or the people, recipients out there. I think we all feel that way.

Evan, from the Kentucky Home Care Association, it's not on the agenda, but since Commissioner Lee is here, is there anything that you would like to address?

MR. REINHARDT: I think a couple of the items on the agenda will touch on that.

We appreciate you being here and we certainly want to make this meeting in particular a productive use of everyone's time.

We've got a couple of agenda items geared in that direction, but I think our approach is whatever we can do to be helpful to you as you oversee and administer all the programs that you are overseeing, we would like to be able to offer that.

I know our group is very excited about the opportunity to gather information, put data together and really play a role in Medicaid in general but in the health care landscape more

generally.

We appreciate the opportunity just to be at the table for anything really as things move forward because we know HCBS is going to be a focal point and we're going to need to change.

So, we're really ready for that and ready for those conversations. So, I appreciate any opportunity to move that ball forward.

COMMISSIONER LEE: Thank you.

MS. DYER: I guess the first thing on the agenda, then, is the approval of the minutes.

MS. STEWART: I make a motion.

MS. PURDON: I'll second.

MS. DYER: That was easy. We can move forward to Old Business. Follow-up on the MCO request for a full listing of supplies and billing quantities. Is the supply formulary being consistently used?

And I'm going to ask Susan Stewart to address that because I think she spent some time looking and the ask is hers.

MS. STEWART: Yes, the ask is mine. This has been an ongoing issue for probably

close to a year now that we brought to the table where as a provider, we don't know what the billing quantities are for each MCO.

For a box of 4x4's, it might be - a box is fifty but one MCO might require forty-eight, one might require forty-five, one might require sixty-two. We have no idea.

So, we asked for a comprehensive list of each MCO's supply list, and this is our second time we've gotten information from the MCOs and it is still not all inclusive.

I picked one item, the one that I pay close attention to and it's foam dressing. And on the WellCare list, the maximum units is zero. On the Passport list, it wasn't included at all and there were only thirty-one items listed on their comprehensive list.

On Humana, the quantity limits were blank. On Anthem, the quantity limits were blank, and Aetna's list was less than thirty-one items.

So, they are not giving us an all-inclusive list of information.

MS. HUGHES: Okay. So, Commissioner, do you mind if I address this?

COMMISSIONER LEE: Go ahead.

MS. HUGHES: We've now worked with the MCOs in getting this. We've provided it to you all twice.

At the last TAC meeting, we specifically told every MCO that was here, you confirm what you have sent to me is accurate and complete and re-send it to me. They re-sent it to me and I sent that all out to you all last week.

At this point, because, as you said, it's been going on a year, I think it's probably going to be best if you all supply us a list of codes that you want to see.

Then, we will send that list to every MCO and we will say don't put zeros, don't leave blanks. You provide us with the information they're requesting for each of these CPT codes, or I guess they're still called CPT codes.

MS. STEWART: HCPCS.

MS. HUGHES: HCPCS codes. That way we get - I mean, that' kind of the route we went at the MAC because Chris Carle kept asking for different information and different MCOs were coming back with different things.

So, I said to Chris, okay, you

provide me a list of everything you want and I will send that out and we did and we got him exactly what he wanted.

So, I think if you all can provide----

MS. STEWART: Our supply list is thousands and thousands and thousands of lines.

MS. PARKER: Trying to help in this whole process, truly understanding what you want, if yours is thousands and thousands of lines, the MCOs could be thousands and thousands of lines as well.

Is that what you're expecting or are there certain ones that you use the most often, that are different, or can we somehow narrow this down to make sure that you are getting exactly what you're asking for?

MS. STEWART: Well, I mean, I'll take Humana and Anthem. They gave us the code but the number was blank.

MS. PARKER: So, that could potentially mean zero.

MS. HUGHES: There's no limit.

MS. STEPHENS: Right, and----

MS. PARKER: Or no limit.

MS. STEPHENS: And I think----

MS. STEWART: But we know that's----

COURT REPORTER: Wait just a second. One at a time.

MS. STEWART: But we know that that's not accurate because we get the denial.

MS. OWEN: What is the code that I can check?

MS. STEWART: A6212 is the one code that I particularly pay close attention to.

MS. PARKER: 212 you say?

MS. STEWART: Yes, A6212.

MS. PARKER: And that was Humana and Anthem.

MS. STEWART: Yes. So, they provided the number but it was blank.

MS. HUGHES: They were to confirm that it was accurate. WellCare, I think, met with you individually on some stuff of why----

MS. STEWART: WellCare is the group that led us to the discussion about why it's a mystery and, so, they said we're not going to tell you. So, we brought it here to try to get an

answer.

And, so, for the Commissioner's purposes, we bill a claim and we bill forty-eight. We get a denial that it's excessive. We don't know what excessive is. So, we bill again at forty-six. It might pass or it might not. So, if it passes, is it forty-six or forty-seven.

So, it's a constant rebill, rebill, rebill to try to figure out what the magical number is for each and every MCO, where, if they would just give us the number, it would save a whole lot of red tape.

MS. STEPHENS: If we could have some examples or something sent.

MS. STEWART: Well, I mean A6212.

MS. PARKER: It would be great if you could send me specific examples where you're seeing a discrepancy and, then, I can get with those MCOs; but to your point, I know there's a lot of supplies out there, but if you are seeing commonalties that are being denied, you billed forty-eight but their limit is forty-five or you're seeing these denial reasons, that would help a lot.

And I don't know, because the

last meeting is the first one I've been to in a while, whether or not you had actually had meetings with the MCOs regarding the supplies.

MS. STEWART: We have met with WellCare.

MS. PARKER: Okay. Have you gotten it figured out with WellCare?

MS. STEWART: No.

MS. PARKER: Okay.

COMMISSIONER LEE: So, what your request is, to make sure I understand, you submit a claim and you will have a list of supplies within that claim and you will have a quantity with that supply. And when your Remit Advice or whatever comes back, it will have a denial with just an exceeds and it doesn't have anything.

So, your quest is to say here's a list of supplies. We want to know per MCO what the billing quantities are for each of those supplies.

So, I think if we start with the top maybe twenty-five. You say there's a lot. Maybe start with the top twenty-five codes that you bill most often and, then, we'll just have to start going down that list, but if we work on the top

twenty-five first.

And, I think, too, another distinction that we need to maybe include in there are those supplies billed most often for adults or children because there are some around children that we have the EPSDT----

MS. STEWART: This is just plain certified home health is all my ask is about.

COMMISSIONER LEE: Okay. So, do you all bill for children? Do you bill any services for children?

MS. STEWART: Not like an EPSDT program. We don't. Do you get a lot of supply denials?

MS. DYER: We bill supplies for EPSDT Special Services but we bill them through whatever plan the child has.

COMMISSIONER LEE: And you don't have any issues with denials on those?

MS. DYER: We haven't had those issues for awhile but it's not to say that we couldn't again or that we have not had in the past but we sort of see a rolling problem sometimes with different agencies having problems, would you say?

MR. REINHARDT: Yes.

COMMISSIONER LEE: Okay. So, we'll just keep this request simple, top twenty-five supplies that you want to see and the quantity limits by MCO.

MS. DYER: One thing that we might add to this, I do believe on some of the limits, there's a duration. For instance, you could have "x" number of supplies in "x" number of weeks or months. Is that correct, Susan? Have you seen that as a problem or Annlyn?

MS. PURDON: Some is per day. Like, Ensure is per day on some.

MS. STEWART: I don't think nutrition was our issue. It was PleurX drains, 4x4's.

MS. DYER: You could only have so many in a certain amount of time which is very patient-specific for a PleurX drain, for instance, right?

MS. STEWART: Yes.

MS. DYER: Wasn't that one of the discussion examples?

MS. STEWART: PleurX drains was one, too. Their limit is ten. We now know for one MCO it's ten. Well, ten at a time. We put twenty

on the line item. They denied ten. Until you go back and forth with them, you don't realize that it's ten each week. And if we had been given ten each week, we would have been fine, but we gave them twenty at a time and that was denied.

So, it's a puzzle. It's a game.

MR. DOUGLASS: Are you having similar problems with the fee-for-service Medicaid?

MS. STEWART: It's all Medicaid.

MS. HUGHES: Fee-for-service as opposed to each MCO.

MS. PURDON: Traditional Medicaid, I still have the list and we go by the list and we have the quantity limits for traditional.

MS. DYER: It's all MCO.

MS. STEWART: It's all MCO.

MS. DYER: Any other discussion?

MS. STEWART: We'll get that. Do you want us to send that to Sharley?

COMMISSIONER LEE: Yes, please.

MS. DYER: All right. So, New

Business. What role the administration expects Home Health to play as it moves forward. What changes/ opportunities are on the horizon and what can the industry do to help gather information/data in order to facilitate those changes. If none have been contemplated, can we make suggestions about how to move forward?

And I think that takes off what Evan said to you and what you really said, too, Commissioner Lee.

COMMISSIONER LEE: So, I think the focus, our priorities in this Administration is definitely going to be reducing barriers to care, ensuring access to care.

So, when we can identify those barriers and come together as a group and talk to see what we can do to improve access, focus on quality of care, too. We don't just want individuals going to care just to get care. We want to make sure they're receiving the appropriate care in the appropriate setting at the appropriate time.

So, those are our priorities, making sure individuals first, number one, can get into the program, can enroll in Medicaid; number two, once they are enrolled, make sure that they

have access to care. So, those are our priorities going forward.

And, of course, you, again, like I said, are out in the community. You're the providers. When you see issues that you think is preventing individuals from receiving care, I think we need to get together.

And I think I'm going to segway into the next bullet point here. We need to start getting some actual data for us to look at. If we see an issue that we think is a barrier to care, we may need to start examining that by looking at data in our system or trying to figure out where we can get information to see if this is a one-time issue or is it going to turn into a broader issue that we really need to address through some sort of policy.

And, so, with that in mind, I think Sharley has taken a lead on actually designing some reports for some of the Technical Advisory Committees so that you all will have information to look at.

I think we're going to start out very basic with information. We're not going to bring you these huge reports that you're not going

to be able to wade through and understand and maybe not make connections.

But we're going to start out with some basic information and let you guys review it and then see what we need to look at going forward, because what we want to move forward with is making data-driven policy decisions.

And what is our data telling us? For example, we could look to see where there are access issues in the state because there are not enough providers, where is the heaviest utilized area, what population is using the services, those kinds of things.

And I think if we look at the big, broad picture first, just get the whole picture of home health, who is using the home health services, what services are they using, we can kind of then start drilling down into the MCO reports and kind of break out just utilization patterns.

But we really see this TAC as looking at that information and help us drive policy decisions. We want to focus on what can we better do to better serve our individuals.

MS. DYER: Thank you.

MR. REINHARDT: The current

arrangement and agencies work most often with Managed Care and we're in a very traditional, just you provide the service and you get paid for that service. Even though you have an individual contract, it's sort of one dimensional.

So, I think our group, in order to be creative and knowing that there's a finite amount of dollars out there, I think there's some opportunities for agencies to work with MCOs in creative ways.

But some of that, I think, will have to come from the Administration itself helping to facilitate opportunities where an agency can take on a more creative, and I don't want to say upside and downside risk right out of the gate, but at least allow agencies to share in some of the upside for providing quality care, for hitting certain outcomes, even as basic as they might be to start, just preventing a hospitalization.

There's a lot of dollars that would normally have been spent there that an agency could put to good use, particularly in a rural area.

So, getting creative about those contracts we see in other states in managed care environments where agencies, even individual

agencies can begin to address particular issues.

And I think our group in particular is ready to come to the table to be able to maintain people in a way that allows them to stay in their home and can keep that quality of care at a high level.

So, I think we would just encourage those conversations to allow some of the dollars that are already in the system to be spent or used more creatively and I think it's a win/win.

The agency can address some of the workforce issues they might be having, and, likewise, the MCO and the Administration gets the outcome that they're looking for.

So, I think that's one suggestion from our side of the fence on how we might be able to move forward in a way that starts to change the paradigm a little bit just because we've been sort of doing things in kind of a traditional model and this would get outside of that a little bit and incentivize everybody here around this table to do some of those things.

So, just a thought there about how we can align, to your point, the service received and the dollars to really target particular

populations.

COMMISSIONER LEE: I think we're open to that recommendation, and I do think that the basis and the jumping-off point is getting that data and starting to look at it and find out where we can make those changes and, again, drive positive policy but on factual data that we have.

MR. REINHARDT: Absolutely. And that's where we would be happy to play a role in that and allow the data to lead us down the path, but I think just that, a dollar spent in an institution compared to in the home and community, that sort of argument is where our focus is, that we can provide hopefully some similar or better outcomes overall and do it in a way that might save some dollars.

So, I think we would be definitely very interested in seeing what the data is and, then, developing a system that aligns with the data.

MS. DYER: I think at this point, Susan, do you have anything to add to what Evan says and, then, Annlyn?

MS. STEWART: I do. If I can remember them both, I've got two.

One of the things I would be interested in from a report standpoint is what I call the new waiver which is----

MS. DYER: Version 2.

MS. STEWART: The Version 2 waiver. I'd like to see the data related to how many people are enrolled in the program because----

MS. HUGHES: I'm sorry. Version 2 waiver?

MS. STEWART: The one that changed it from homemaking and personal care----

MS. DYER: It's Version 2.

MS. HUGHES: So, the waiver. Back here, the waiver.

COMMISSIONER LEE: So, if I could speak to that - I'm sorry, I forgot to speak to that - just for a little bit.

I know that there's been a lot of work and energy put into the 1915(c) waiver redesign I think is what you're talking about.

MS. STEWART: No, because that's kind of gone, right?

COMMISSIONER LEE: No, no. There's been a lot of effort, like I said, and energy put into the 1915(c) waiver redesign.

And there is a report, I think Navigant created a very comprehensive report with some recommendations, and the Department had been moving forward with implementing some of those recommendations.

And, so, what we're looking at now is we are kind of taking a step back. We're looking at which of those recommendations that we can implement within our current infrastructure that's going to improve the delivery of care to members, reduce administrative burdens for providers and the Cabinet because we have sister agencies who work with us in administering those 1915(c)waivers.

So, the one thing that we're taking a pause on and looking back on are some of the bigger changes that would require waiver application amendments, that would require regulation changes, those sorts of things.

For example, I know that there was a rate study that most of the providers received and it switched some of the provider rates or it changed some of those.

We really want to look at that to make sure there's not going to be any unintended consequences moving forward. So, we really want to

look at these, at the 1915(c) waiver redesign in a more thoughtful, methodical manner going forward.

So, we're putting a pause on some of those major changes, but the quick wins that will help us deliver those services more efficiently that we can do within the current infrastructure we want to go ahead and implement, and we'll keep all providers in the loop on those communications.

MS. STEWART: I was more interested in a very higher level than that.

MS. HUGHES: Now, the waiver you're talking about that went away is the Kentucky HEALTH waiver. Is that what you're thinking?

MS. STEWART: No.

MS. DYER: Well, there was the Home- and Community-Based Waiver and, then, we had a rewrite that is Version 2. That's what we're kind of living under but actually it has been modified to the point that it's not exactly what Version 2 was.

But I think what you're speaking about is before Version 2 was implemented.

MS. STEWART: Right, the old Home- and Community-Based Waiver Program and 12,000 open slots.

I'm interested in data related

to how many patients are being served now and are there still open slots, and what kind of providers are providing care in that program because when it was rewritten, a lot of home health agencies, including mine, got out of the program.

So, I'm interested to see if there's access-to-care issues because I know patients in our area are going without care because there's not enough providers. That's the high level I was interested in, but I love all that other stuff, too.

COMMISSIONER LEE: So, basically, the HCB waivers?

MS. STEWART: Yes.

COMMISSIONER LEE: You want to see some utilization trends in that waiver.

MS. STEWART: Yes, ma'am. And the other thing I wanted to mention is tagging on to what Evan said.

Probably two years ago or maybe three years ago, our TAC was a little dysfunctional and made great strides in getting functional again.

We got a new Commissioner that said halt, you can't talk about any of these things

here anymore. We want you to be visionary. So, I'd like to see us get back to where we are a partner with DMS staff and people are engaged with us so that we can build relationships with them so that we can be harmonious again.

COMMISSIONER LEE: And I think that that's what we all want here at the table. I think our vision is that you are visionaries, that you help us identify areas that need to be improved and maybe see what kind of policy recommendations that we can make, but also we need to know what's going on in the field to know what issues are out there and what we need to work on. So, I think it's a combination of what you just said.

MS. DYER: And just before Annlyn goes, just a little take on what you said, just to clarify, I guess, is what I'm asking.

When you're talking about some of the things that you're looking at with the new version that was a couple of years pretty much has been skin on, the third iteration, I was on that rate study committee, by the way, as a member for Kentucky Home Care. So, we're all interested in that and what that looks like.

The one thing that we're

interested in as an agency and I think this would lead into what Susan is asking and probably Annlyn and many more people in Kentucky Home Care is the application process.

For instance, we are a Home- and Community-Based Waiver provider, but we are interested at a point in looking at being a Michelle P. Waiver provider.

So, we were told that possibly in some of that, this third iteration of rewrite, that that was being looked at to streamline the application process. So, pretty much, if you applied to be one waiver provider, it could carry over into the next waiver that you might be looking at to provide.

So, it would help access to care if you don't have to go through a huge process to be in an additional waiver, and I would imagine my agency is not the only people in the state that might want to look at that.

It might really open up access to care, but there were lots of providers that did drop out when it went to Version II. We just tried to see what happened and it has worked well. For a small agency, we had over 300 a couple of weeks ago.

Anyway, Annlyn.

MS. PURDON: you all made all the great points. I would just be interested in the waiver to have a seat at the table and be able to make comments on upcoming changes because the administrative burden for waiver is huge compared to the original waiver and it makes it very hard to be a provider.

COMMISSIONER LEE: And is that for HCB waiver or is that----

MS. PURDON: HCB.

MR. DOUGLASS: I have a question when we were talking earlier about making sure that our recipients receive care that they need.

I've known that in the last few years, there have been some home health agencies that have closed their doors.

As an Association, what is your role in hopefully having someone either expand to be able to cover that area or to maybe encourage or back someone to reopen because I know that especially in Eastern Kentucky and with Martin County closing, I know that some of the nurses that are in home health up there have to drive compared

to what they were driving, they were in one county, now they're in three counties and stuff like that.

I was just wondering if you all encourage people to become home health agencies or what that process would be to try to fulfill that gap.

MS. DYER: Would you like to answer that?

MR. REINHARDT: Sure. You're in a little bit of a tough situation just because when you get into the CON process, you don't want to appear favorable to one agency and not favorable to another one. So, we try to be sensitive to that.

More so, we try to feed information. So, when an agency does close or a CON, we just provide that information.

I think one agency or two this past year, they sold their CON. So, we helped facilitate spreading that information that there were opportunities out there. I think one of the agencies wasn't even using the CON. So, we tried to facilitate the spread of that information.

We definitely encourage outside entities and we're actually based, for those that don't know, my organization is based in Indiana

and we have an agreement with the Kentucky Home Care Association to manage their entity.

So, we touch with all sorts of agencies that aren't in Kentucky and have that conversation about what the needs are, what the landscape looks like in Kentucky and definitely encourage them to look at Kentucky as a place where there are opportunities where people are going unserved or under-served.

So, we definitely try to be that communication hub, but it's also with it being a CON state, that that's a big difference between just facilitating an agency getting a license. Going through that CON process, we have to be pretty sensitive to our members about what sort of positions they take related to CON.

So, that's kind of where we stand in a nutshell. Does anyone have anything else to add?

MS. STEWART: As a provider in Eastern Kentucky, I will say - and it's probably a challenge for them as well - is we struggle finding enough staff to take care of the patients we have.

So, being able - you know, Martin County, we recently acquired Martin County

through an acquisition but it's a long way up there.

MR. DOUGLASS: Yes, it is. You just can't get there.

MS. STEWART: You can't get there and finding someone that wants to be a home health nurse in Martin County is hard. The access to care when you look at the state report, the number of patients that received care in Martin County over the last few years are nominal.

Nursing staff is a big hurdle for everybody that needs a nurse across the state. There's just not enough of them.

There were two. Martin County sold and PMC sold but being Pike County, we're solid there, but Martin County is still an access issue. There's not enough staff.

MS. DYER: And in areas where there's a large concentration of nurses, there's a large entity, they can go anywhere and get a job basically, bottom line.

MR. REINHARDT: A lot of competition.

MS. DYER: A lot of competition to get as nurses in home care for all of us, whether you're public home health like we are or private or

whatever. We're a rare commodity anymore.

MS. STEWART: We are a rare commodity because when I talk to our Board about Home Care and ARH, one of the things I always hone in on is we don't have security and we don't have a call bell. To work in home health, it takes special people and they are getting farther and fewer between.

MS. DYER: We have had the opportunity - and we're a public home health, so, we have been able to stay in Home- and Community-Based Waiver to do more focus really on providing that level of care which we feel good about.

We don't feel good about not being able to do traditional like we used to be able to do it, but to your question, Charles, there's a huge focus in our agency on Home- and Community-Based Waiver now, as well as EPSDT Special Services.

That's been for a long time, but we do want to grow the waiver program because we know social workers can work in that program. It's a good program and we're glad it's around.

MS. STEWART: Something you might want to dive into some reports is I would ask

you to look at Medicaid utilization across home health providers. I think you would find that very interesting.

MS. PARKER: Meaning who orders it or meaning who is providing it?

MS. STEWART: Meaning who is providing it. I think you will find large disparities.

MS. PARKER: And why do you think that is?

MS. STEWART: Because some people have a mind set for mission and patient care and some people have a mind set for profitability and no one provides care for Medicaid patients to make money but there are lots of agencies out there that have 95, 98% Medicare and 2% commercial and 0% Medicaid.

MS. PARKER: Do you have a map of some sort that kind of shows where all the home health agencies are located in the state - I guess I'm talking to you since you kind of manage this - and the areas they serve?

MR. REINHARDT: The OIG keeps track of who has a license in each particular county. So, that's how we keep up with that because

those things change through the CON process. They publish an Excel spreadsheet that has that information on a semi-regular basis.

MS. PARKER: On their website?

MR. REINHARDT: Yes.

MS. HUGHES: To your request about that, the only data we would be able to look at is the Medicaid, those that are providing Medicaid services.

MS. STEWART: No. You have access to an annual state report that we submit, that every home health agency in Kentucky submits.

MS. HUGHES: Who do you submit that to because what we're looking at is Medicaid.

MS. DYER: The name has changed. It's different. We'll get that to you. I have it in an email but I won't get in my purse and drag that out but where we submit it, the state survey report, but is it broken down by Medicare? I don't think Medicare is on there. It's just numbers by services or programs. It's broken down by EPSDT, for instance, but I don't recall----

MS. PURDON: We don't even submit waiver on it anymore.

MS. DYER: No. Waiver is not

on there.

MS. HUGHES: So, that would not be something that would be accurate.

MS. DYER: It would have to in combination with the OIG, the OASIS coordinator maybe.

MS. STEWART: Maybe.

MS. DYER: And maybe Kentucky Home Care, too. I don't know. It would have to be a group of people that could help look at the percentages maybe. CMS, though.

MS. REINHARDT: To Susan's point, if you have a CON, it's going to be for a county. And if a county only has "x" amount of Medicaid services versus a population of "y", I think that would paint the picture about what their balance of reimbursement would be.

MS. DYER: With traditional home health, you don't report it by payor, though, on that state survey report. It's just a number of traditional that you report.

MR. REINHARDT: That makes sense. I think from their side of it, they might be able to get the billing information.

MS. DYER: You might. It has

to be out there somewhere. It might have to come from more than one place.

Okay. Any other discussion, comments on that?

This is not on New Business, but one of the asks that we're going to have as a TAC and I think we have been doing this a little bit is for each MCO, if you have something new you want to share with us, and you may or may not be prepared to do that today, but if you would like to share that, we would very much like to hear that.

MS. STEWART: And we'll start with Pat.

MS. RUSSELL: Thank you, Susan. I was going to say I can't really think of anything that we're doing right now that will impact home health. I mean, you guys have been a part of us for a long time and it's been kind of traditional what we do with the home health.

I will tell you guys that we are planning our summits coming up in May where we go across the state in different areas and invite all the providers to come and listen to what's going on with us as an organization.

We'll have individuals there

to talk to you about home health specifically, if you've got any claims' issues or problems or any of that kind of thing. So, that's about all I can think of that would impact you guys right now.

MS. DYER: I'll give you permission to share our problem last week, if you'd like to share it, about patients can get services at an outpatient and with us. That's huge for EPSDT Special Services.

MS. RUSSELL: Billie contacted me a couple of weeks ago with an issue where one of our representatives had informed her that if you're doing services on a particular child, an EPSDT, and they're getting OT, PT and ST, then, all three of the services had to come from a single provider.

So, in other words, with home health, typically what would happen was Billie would send one of her OT specialists, an ST and a PT all to the home to provide the services.

But due to a factor outside of her control, she didn't have an OT, I think it was, at the time to go do the service. So, our Provider Rep told her she couldn't go outside and get those services provided by another entity while that child was under their care plan and that is not the case.

As long as it's documented in the care plan that you're doing OT, PT and ST and one particular service is being done by another provider, that's perfectly fine.

MS. DYER: And that was huge and we very much appreciated you getting involved in that. Thank you.

MS. RUSSELL: Glad to help.

MS. DYER: Anybody else like to go? Medicaid might want to say something, too. It doesn't have to just be the MCOs.

Does Aetna want to say anything?

MS. ROSE: I apologize. I seem to have lost my voice with the weather. I'm JoAnn Rose. I manage the Network Relations Department.

The big thing that I would just like to point out is we're starting our we call it AP3 but it's the Aetna Provider Partnership Program. It's basically a provider advisory board and we've got three kind of mini workgroups and one of them is an ancillary group.

So, I do have some emails out to some home health providers to see if they would like to join the council just to kind of meet and

the goal is to work with us, individual providers, on any kind of an administrative burden that we can reduce and look at those things.

So, if you've gotten an email from me recently, that's what it's pertaining to. If you want to join the council or you want additional information, please find me and I'm happy to share that, but we're actually kicking that off.

We put the program together in the fall of last year and we kicked that off this month. So, we'll be going forward.

MS. DYER: Humana.

MS. STEPHENS: We don't have any updates today.

MR. CUSTERS: The only thing I would say is since I was chosen to represent the Provider Relations' side, if there's any information, since we're just starting this year with the Medicaid plan, that you would like, I can email out all of the different links and new information and contact information and authorization information. If I can get a list of email addresses, I'll be happy to send that information out.

MS. DYER: If you get the

information to our Executive Director.

MR. REINHARDT: If you would give me your card, we can follow up.

MS. HUGHES: You can send it to me and I will send it out to the TAC members.

MS. DYER: And I think you're speaking that you're back to Humana. Humana-CareSource has been around but you no longer----

MS. STEPHENS: We ended that relationship with CareSource as of 12/31 and now we brought everything back in-house at Humana. So, yes, same members, still serving the same members but just brought it in-house.

MS. DYER: Anthem.

MS. OWENS: Holly Owens with Anthem. I was not prepared to do a speech. We don't have anything that is changing. We have a health fair coming up March 14th in Louisville. It's going to be pretty big, but before the next meeting, I will touch base with all the different departments and see if they want to share anything at the meeting.

MS. DYER: Okay. Passport. Is Passport here? And Medicaid, is there anything else from Medicaid?

MR. DOUGLASS: No, but this is Candace Crawford. She is a nurse who is also kind to take over the home health program as one of her assigned duties.

MS. DYER: It's nice to know what you're doing. Thank you, Charles. Any questions?

MS. STEWART: Sharley, when you send stuff to us, is it okay to include Evan on that, too, because we forget to forward it to him?

MS. HUGHES: It doesn't matter.

MS. STEWART: It's fine with us if you do. He's the keeper of all of our stuff. So, when you send us something, just go ahead and include him.

DR. THERIOT: So, are you going to be a member of the TAC?

MS. STEWART: He is the Executive Director of our Association.

MS. HUGHES: He's not a member of the TAC, no.

MS. STEWART: He can't be a member but he represents us.

MS. DYER: Do you all have any further questions for us while we're here and we've

got just a little bit of time because we do want a partnership.

I think we had quite a bit of discussion about whether we're going to have this TAC meeting. And just to go on record, this group wants a routine meeting so that we do keep that open. And I know it's hard for everybody to get here but we so appreciate you coming.

We're very glad to meet you, Commissioner Lee, because it is a partnership. And if we don't view it that way, then, there's gaps and barriers that come up that we can't even imagine.

So, we're very glad you're here and we're very glad to meet you and good luck with your role. You've got a lot to do, I know.

COMMISSIONER LEE: Glad to be back.

MS. DYER: We're thankful for everybody that comes, but we do want to have this routinely and keep that. We feel like there's a big gap. I know sometimes you have trouble getting everybody here, Sharley. You try your best to communicate back but that's how we feel.

We feel like four months is a long time to not meet. If there is something, then,

we want to feed it up to the MAC to work through it. And I hear you say you want us to be a working group to feed information, vision, but also to bring the barriers. So, I think that we can work towards that goal.

MS. HUGHES: And the reason that I asked did you all want to cancel this one was because there was nothing on the agenda. Like, I know Susan drives 300 miles and do you want to come with no agenda items.

MS. DYER: We always seem to have something or something comes up in New Business. I understand and thank you for being that considerate, though.

MS. STEWART: If nothing else, we want updates from MCOs and updates from Medicaid if we don't have anything else because I'm sure from that discussion, something will bubble up. And this supply thing will be an agenda item until it's resolved. So, you can count that one in.

MS. HUGHES: But you're going to get me a list.

MS. STEWART: I'm going to.

MS. DYER: If there's nothing else, then, do I have a motion to adjourn?

MS. STEWART: So moved.

MS. PURDON: And I'll second.

MS. DYER: We are adjourned.

Thank you all so much.

MEETING ADJOURNED